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Therapeutic advantages of CHLOROMYCETIN (chloramphenicol, Parke-Davis) are especially appreciated when mixed infections are encountered because it provides highly effective antibiotic action both against gram-negative and against gram-positive pathogens.[1-7] CHLOROMYCETIN also acts against many pathogens which may grow when originally sensitive organisms have been suppressed.[2]

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CHLOROMYCETIN is a potent therapeutic agent, and because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

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Editorials

Gift From the Dead

Recently the following editorial appeared in the Tulsa Tribune:

"The word 'autopsy' has certain unpleasant overtones to many people. But it shouldn't have. An autopsy or post-mortem examination can be—and repeatedly has been—the dead's finest gift to the living.

"The deceased person, through careful examination at the hands of doctors and pathologists, is saying to those he left behind, 'Here is knowledge of why I died. Use that knowledge to help keep yourselves and others from dying from the same cause.'

"Fortunately for all of us as well as for medical science, what once was shocked resistance to post-mortem examination now is being overcome by tact and education. Surviving relatives, who must give permission for it, are learning that there is no careless cutting on the loved one's body, no callous experimenting, no irreverent handling by untrained hands.

"Neither is it dissection, in the broad sense of the word. In most cases there is little or no evidence that a bit of tissue had been removed or an organ hidden during life had been examined to see why it failed.

"The list of troubles once deadly but now curable or treatable because of autopsy findings is long. Appendicitis was an agonizingly fatal "generalized inflammation of the bowel" until post-mortems discovered its cause and cure. Congenital heart defects, unknown only a generation or two ago, now are giving way to surgical miracles because autopsies pointed the way. One million diabetics are thankful because a doctor did a post-mortem in 1900 and found in death a hope for life.

"It is perhaps natural that a bereaved family should prefer to withdrawal in their grief when the family doctor, the surgeon or the pathologist asks permission to perform an autopsy. But the dead should not be denied their last opportunity to help the living."

This piece of prose sounds as if it came from the pen of Sir William Osler himself. One large Oklahoma hospital was so impressed by the article that copies were sent to every member of its staff. The common sense and shining beauty of this editorial are so great that the *Journal* reprints it here for the benefit of all our readers.

Doctors and Politics

A disturbing article bearing this title by Doctor David Rutstein, head if the department of preventive medicine at Harvard, appeared in the current (August) issue of the *Atlantic*. Doctor Rutstein denies the right of a physician to a political interpretation of medical information but is nevertheless quite sure that Mr. Eisenhower because of his two chronic diseases is not a suitable candidate for the presidency.

In three separate studies the five-year survival of patients who do not die with their first coronary occlusion is 50 per cent. The first of these studies was reported by Doctors Edward F. Bland and Paul D. White of Boston in 1941. Doctor Rutstein infers that Doctor White was something less than honest when he stated, considering President Eisenhower in his recovery: "The majority of patients that I see with this condition do well." In Doctor White's mind the word *condition* must have meant not just any coronary occlusion but an occlusion qualified by the location, the extent of muscle injury, the degree of shock, the evidence of conduction disturbance and other limiting factors that applied to the President's case.

The author takes exception to the announcement of his physicians of February 1, 1956 when he had practically recovered from his coronary thrombosis: "The President should be able to carry on an active life satisfactorily for another five to ten years." He thinks that this gave the President no choice

on medical grounds of refusing to run for re-election. These men are cardiologists or were guided by cardiologists who are quite as aware of the published statistical data on coronary disease as is Doctor Rutstein. Their conclusions referred to the President not to coronary thrombosis. No one knows how long an individual will live nor when he will die. The 50 per cent figure is not intended to tell this, but future figures will tell whether or not we are improving our ability to treat and to care for these people. The phrase *for another five to ten years* does have political implications and should have been omitted, for if his physicians could see no reason for earlier limitation they could not possibly see a reason for a later one.

After reading this article several times the following conclusions seem justified.

1. A lay publication may be a safer forum for such a discussion, but it is not the best.
2. Highly respected periodicals such as the *Atlantic* would do well to seek competent medical advice before accepting papers of a medical nature.
3. The physician's responsibility is to his patient and to the patient's family, even though he be President. He must give to the patient and his family the best advice that he possibly can, not only in regards to his illness but also the effect of his illness on his future activity and vice-versa.
4. A case may be a statistic but a patient is not.

Announcing . . .

the completion of the New State Headquarters Building

The Executive Offices of the Oklahoma State Medical Association were moved to the new building on September 1. The building is located at 601 Northwest Expressway, Oklahoma City. An open house for physician members is tentatively planned for the middle of October. Upon the completion of final arrangements, physicians will be notified of the specific date in the October issue of the JOURNAL and by personal invitation as well.

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Scientific Articles

POISONOUS PLANTS

H. A. SHOEMAKER, Ph.D.

THE AUTHOR

H. A. Shoemaker, Ph.D., is Professor of Pharmacology at the University of Oklahoma School of Medicine, Oklahoma City. His article on Poisonous Plants is the second of a series to appear in connection with the setting up of the Poison Information Center at the University School of Medicine.

There are approximately 525 species of plants in the United States that are known to poison domestic livestock or man. Only a comparitive few are ordinarily likely to be ingested by man. Most cases of poisoning from plants or fruits occur when they are mistaken for some edible species; or when children, particularly the very young, have access to the plant or fruit and eat it. The information regarding plants that are toxic to animals is much more complete than for those which are poisonous for humans.

There is some misconception regarding the plants which are toxic for the human. A statement which is frequently heard is: "Birds and animals eat the seed or fruit and therefore it is safe to eat it." The fact that birds or animals may eat the seeds or fruit is no criterion for judging the safety for man. There is a difference in species susceptibility. For example a rabbit can eat the leaves of some members of the nightshade family almost with impunity, but all parts of the plant are poisonous for man.

The following list of poisonous plants is not complete. Only those cultivated and wild plants which grow in Oklahoma and which are most likely to be involved in poisoning are included. It is possible that some have been omitted that should have been included or some that are in the list could have been omitted.

The treatment when some part of a plant or some fruit or seed has been eaten follows the same general lines that is used following the ingestion of any toxic substance: The removal from the gastro-intestinal tract as rapidly as possible by emesis or gastric lavage, and catharsis; a delay in absorption by the use of adsorbants such as activated charcoal or the universal antidote (one part tannic acid, one part magnesium oxide, two parts activated charcoal); the precipitation of the toxic substance, such as alkaloids, by tannic acid alone or in combination with the ingredients of the universal antidote; or the destruction by oxidation by using a 1:10,000 solution of potassium permanganate for the first washing. Whenever adsorbants of precipitants are used they are removed by lavage, although in the case of the universal antidote a small amount of the mixture (2 tablespoonsful per quart of water) may be left in the stomach. If catharsis is indicated, sodium sulfate 2 - 3 gms. in water is a safe and effective agent for a 2 - 4 year old child. The adult dose is 15 - 30 gm.

The treatment subsequent to emptying the gastro-intestinal tract is usually expectant and symptomatic. There are only a few instances in poisoning by plants, fruits, and seeds for which there are more or less specific antidotes.

The following outline is modified from Martin:

I. *Irritants*

The largest group of toxic plants are those which produce irritation. The skin irritants are not included because the rashes are usually of a minor nature except with poison ivy, poison sumac, or poison oak. The treatment of these is very adequately covered in textbooks of dermatology.

1. *Irritants of mucous membrane of mouth and throat.* These substances produce almost immediate reaction when crushed in the mouth and consequently are usually not swallowed. The pricking and

burning sensation is followed by redness and swelling. This swelling may be severe enough to interfere with speech. If swallowed, these plants can produce a very severe gastroenteritis with shock.

Caladium	Diffenbachia
Calla Lily	Elephant Ear
Ceriman	

The mouth should be thoroughly washed with water to remove any remaining particles. Other treatment is symptomatic.

2. *Irritants of Gastric Mucosa.* These plants are not as severe in their irritant effects consequently they may not produce any noticeable effects in the mouth and throat. The irritation of the gastric mucosa usually produces prompt emesis. As a result there seldom is any irritation of the intestines.

Daffodil	Lycoris
Grape hyacinth	Narcissus
Jonquil	Rain Lily

The treatment in addition to the removal of the substance is symptomatic. There is no specific antidote.

3. *Irritants of Gastrointestinal Tract.* This group of plants does not produce an immediate irritation of the oral or gastric mucosa and consequently they may be swallowed and are not removed by their emetic action. They, therefore, may produce a generalized gastroenteritis of different degrees of severity.

Black locust**	Jequirity**
Castor bean**	Mimosa*
Clematis	Mock orange*
Colchicum	Peony
Columbine	Phytolacca*
Cyclamen*	("Poke")
Four O'clock	Poinsettia
Iris	Privet
	Rain tree*

Those plants which owe their activity to the presence of saponins* may produce a depression of the central nervous system and occasionally stimulation resulting in convulsions. In the case of Phytolacca the symptoms develop fairly rapidly and the syndrone is characterized by a very severe gastroenteritis accompanied by a respiratory and vasomator depression. The treatment is symptomatic: an opiate analgesic to relieve pain and the correction of electrolyte and fluid imbalance.

The most deadly plants which produce vomiting and diarrhea are those that contain toxalbumius**. Of these the castor bean is the most frequent cause of poisoning in children. The toxicity is due to the ricin which is present and 5 - 6 beans may be fatal to a child. The symptoms are a very severe gastroenteritis and its concomitant effects. There may be convulsions. There is usually some delay in development of symptoms. The treatment again is supportive and symptomatic.

II. *Plants which have an Atropine-like effect.*

Belladonna
Bittersweet
Black Night-shade
Jimson Weed (Datura stramonium)
Henbane
Moonflower (Dature meteloides)

The symptoms of poisoning by these plants is characterized by a dryness of the mouth, difficulty in swallowing, dilation of pupils with loss of accomodation for near vision, and tachycardia. Flushing of the skin is marked, especially about the face and neck. The skin is dry and hot. Cerebral stimulation results in restlessness, mental confusion, and sometimes delirium and convulsions. The symptoms of stimulation may be followed by depression.

The treatment consists of control of the excitement stage by means of sponge baths and mild depressants, such as bromides. The shorter acting barbiturates should be used with caution since large doses of atropine may have a synergistic depressant effect. In severe convulsions gaseous anesthetics may be used. Give adequate fluids and if the patient has difficulty in voiding, it may be necessary to resort to catheterization. Excretion of the alkaloids in the urine. Recovery usually is complete in two to four days.

III. *Plants which have a cardiac effect.*

Camelia	Aconite
Digitalis	Larkspur
Lily of the Valley	
Oleander	

The instances of poisoning by these plants is not common. Those in the first column have a digitalis-like effect. The symptoms develop fairly rapidly and consist of nausea and vomiting, and a slow pulse which later may become rapid and irregular. There may

be abdominal pain and purging. The treatment consists of gastric lavage with tannic acid, atropine and catharsis with sodium sulfate.

Do not give epinerphrine or other drugs which have a stimulating effect on cardiac muscle.

The plants in the second column have a tendency to produce bradycardia which is then followed by an arrythmia. There is an immediate burning sensation in the mouth, salivation, nausea and vomiting. Later the mouth is dry and the patient suffers from thirst. There may be diarrhea. With aconite there may be tingling and paresthesias, usually starting at the fingers and spreading over the entire body. Death may occur from circulatory and respiratory failure.

The treatment, following emptying of gastrointestinal tract, is symptomatic. The administration of oxygen and artificial respiration may become necessary. Atropine and digitalis have been recommended in the treatment of aconite poisoning but there has not been any sound pharmacological basis established for their use.

There are a large number of plants which may under some circumstances produce poisoning, but the danger is usually fairly remote. In any case where a part of a plant, a bulb, root, fruit, or seed has been eaten and its probable toxicity is not known, it is advisable to empty the gastrointestinal tract by emesis, lavage, or both and then observe carefully for at least 24 hours. Any symptoms should be treated as they develop as there are very few specific antidotes. Some plants or parts of plants may be used as food in certain seasons of the year. For example, phytolacca (poke) may be used after boiling in water and discarding the water which tends to remove the toxic substance.

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Giant Cell

TUMOR *of* TENDON SHEATH

FRANK L. FLACK, M.D.

THE AUTHOR

Dr. Frank L. Flack is a practicing physician in Tulsa, Okla. He is a graduate of University of Kansas School of Medicine. He is a Fellow of the American College of Surgeons, and a member of the American Board of Surgery. At the present time he is president of the Tulsa County Medical Society.

Mrs. M. R., age 48, was admitted to the hospital September 19, 1955, because of a swollen, painful, infected, bleeding, stinking, sloughing left hand.

The patient had had some pain and swelling of her hand for 10 years but had continued her employment as a maid in a hotel until shortly before admission to the hospital when she caught her hand in a clothes wringer. This forced her to seek help because of greatly increased pain.

The past history was non-contributory except for the disability of her hand. She had had no shortness of breath and no symptoms of fatigue or exhaustion.

She was a well developed white woman, height 62 inches, weight 135, blood pressure 140/70, temperature, pulse and respiration essentially normal. Her physical examination was essentially negative except for the affected hand. There was a tumor mass measuring 20 cm. x 15 cm. involving the entire left hand. The fingers seems to stick out of the mass. There were many ulcerations, some of them 3 x 4 cm. in diameter. The whole mass was hot, red, tender and foul smelling. Urinalysis showed 1+ albumin and many white cells. The W.B.C. was 10,400; RBC 1,500,000; Hb. 3 gms. An

x-ray film of the hand showed erosions of the cortices of the metacarpals and phalanges with dislocations of some of the joints. Examination of bone marrow showed normoblastic erythroid hyperplasia.

Two days after admission she was given 500 ml. of whole blood. A day later her hematocrit was only 16 and blood volume studies revealed the following:

	Normal	*Patient*
Total Blood Volume	4725 ml.	4209 ml.
Total Plasma Volume	2538 ml.	3577 ml.
Total Cell Volume	2256 ml.	632 ml.

She received 500 ml. of whole blood daily for the next five days and the ninth hospital day after receiving 7,000,000 units of penicillin over this period, the arm was amputated just above the elbow with equal anterior and posterior flaps. Because of the lymph nodes that had been previously palpable, the axilla was opened but no enlarged nodes were found. She was ambulant the next day and was discharged from the hospital on the 12th post-operative day with all of the incisions well healed.

Comment

The tumor on microscopic examination[1] proved to be a giant cell tumor of the tendon sheath. The base of the tumor was situated about the proximal end of the first metacarpal bone. There were fragments of bone scattered throughout the tumor. The flexor and extensor tendons were free. The tendon sheaths were attached to the tumor. In sections there were multiple nodules with

many foam cells. In other areas there were nodules composed of giant cells with the nuclei distributed throughout the cell. All through this nodular tumor were acute and chronic inflammatory cellular elements.

The Armed Forces Institute of Pathology says: "There is no reference of a tumor of this nature having produced metastases and for this reason a diagnosis of pleomorphic variant of giant cell tumor is often made. The British writers in particular regard these tumors as synoviomata and some would regard this tumor as a low grade synovial sarcoma or malignant giant cell tumor.

"In this case spindle and pleomorphic areas were intermingled with accumulations of foam cells. These foam cells seem to be of special significance, since they are rarely seen in malignant tumors thought to arise from periarticular structures, but are a characteristic feature of the benign lesions arising in the same structures. A giant cell tumor of a tendon sheath reaching such a size is a very rare finding."

It is amazing that a human being could from chronic blood loss and infection develop this degree of anemia without symptoms of distress though working every day and that in this day of a medically enlightened public, such a person would fail to seek help before she had developed a lesion which reminds one of the horrible conditions illustrated in such old texts as that of Gould and Pyle.

1. D. L. Galindo, M.D.

VISUAL SCREENING *of the Pre-School Child*

ROBERT W. KING, M.D.

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Dr. Robert W. King is a graduate of the University of Oklahoma. His residency training in Ophthamology was taken at Cleveland Clinic and Cleveland City Hospital. He is eligible for the American Board of Ophthamology.

Vision is the process through which we are able to recognize objects of the world we live in. For those who have not been denied it, our thoughts are seldom directed to what a wonderful thing it is, as we accept it as part of our everyday life. But to those who have had some form of a misfortune, the recovery of vision can become quite a serious problem. This fact is often brought home in the practice of the ophthalmologist who sees many preventable tragedies.

In spite of the excellent progress medicine has made, there are still too many instances where useful vision is lost through negligence and misunderstanding. With this in mind, the Oklahoma County Committee of the National Society for the Prevention of Blindness has undertaken a program of screening every pre-school child. This was begun in Oklahoma County with hopes of later extending it to cover most of the state. As one can surmise, this is quite an energetic undertaking, but one that is worth every hour spent toward its accomplishment. Before describing the progress of this program, let's first review why this age child is so critical.

The macula of the eye, that part with which we do our detailed seeing, does not attain full cellular development until the sixteenth week after the birth of the child. Consequently, during the first two or three months of life, the child's eyes may wander aimlessly. Bewteen the second and fourth month of life, the eye begins to develop its fixation reflex, or at this age the baby begins to follow movements with its eyes. From this time until after six years, there is a progressive development of vision, or what the oculists call "visual acuity." On the average, it is felt that by the end of the first year the child sees 20/100; by the end of three years the child sees 20/30; and by six years the child sees 20/20. If, for any reason during this period of development, some process interferes with the use of the eye, than there also will be a corresponding failure in development of vision. This process has been given the highly technical name of amblyopia ex anopsia, which means failure of development of vision from disuse.

Along with the development of vision, there also is developed a fusion reflex, which may be described as the ability of the brain to take the two images presented to it and superimpose them so that only one image is seen. This process begins around the age of six months when the aimless wandering of the eyes begins to cease, and the child readily focuses on objects with both eyes simultaneously. By the age of one year, the reflex is fairly well deep-seated, and its development is completed by the age of six years.

From the above, one can readily realize that the major development of our vision is before we enter school. This age, before six, is not only the most important in the development of vision, but it is also the best age for correcting any deficiencies that may be interfering with the development of visual acuity and/or fusion reflex. The most common critical deficiencies encountered are squints, anisometropias, and refractive errors of high degrees.

In squints, or strabismus, the eyes tend to deviate either in or out. If the squint is constant, then there is essentially no chance of development of fusion. If one eye is selected in preference to the other for seeing, then the deviating eye does not develop vision and becomes an amblyopic eye. A high percentage of convergent squints are corrected by glasses alone. These cases require complete cycloplegic (Atropine) refraction before it can be determined whether glasses are the sole answer. The remaining squints should be operated on or before the age of six, with the better results being obtained from the earlier operations.

Anisometropia means that the two eyes

x-ray film of the hand showed erosions of the cortices of the metacarpals and phalanges with dislocations of some of the joints. Examination of bone marrow showed normoblastic erythroid hyperplasia.

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The macula of the eye, that part with which we do our detailed seeing, does not attain full cellular development until the sixteenth week after the birth of the child. Consequently, during the first two or three months of life, the child's eyes may wander aimlessly. Bewteen the second and fourth month of life, the eye begins to develop its fixation reflex, or at this age the baby begins to follow movements with its eyes. From this time until after six years, there is a progressive development of vision, or what the oculists call "visual acuity." On the average, it is felt that by the end of the first year the child sees 20/100; by the end of three years the child sees 20/30; and by six years the child sees 20/20. If, for any reason during this period of development, some process interferes with the use of the eye, than there also will be a corresponding failure in development of vision. This process has been given the highly technical name of amblyopia ex anopsia, which means failure of development of vision from disuse.

Along with the development of vision, there also is developed a fusion reflex, which may be described as the ability of the brain to take the two images presented to it and superimpose them so that only one image is seen. This process begins around the age of six months when the aimless wandering of the eyes begins to cease, and the child readily focuses on objects with both eyes simultaneously. By the age of one year, the reflex is fairly well deep-seated, and its development is completed by the age of six years.

From the above, one can readily realize that the major development of our vision is before we enter school. This age, before six, is not only the most important in the development of vision, but it is also the best age for correcting any deficiencies that may be interfering with the development of visual acuity and/or fusion reflex. The most common critical deficiencies encountered are squints, anisometropias, and refractive errors of high degrees.

In squints, or strabismus, the eyes tend to deviate either in or out. If the squint is constant, then there is essentially no chance of development of fusion. If one eye is selected in preference to the other for seeing, then the deviating eye does not develop vision and becomes an amblyopic eye. A high percentage of convergent squints are corrected by glasses alone. These cases require complete cycloplegic (Atropine) refraction before it can be determined whether glasses are the sole answer. The remaining squints should be operated on or before the age of six, with the better results being obtained from the earlier operations.

Anisometropia means that the two eyes

have different refractive errors, with the variation usually being greater than 1.50 diopters. Because of this anomaly, the child cannot focus both eyes at the same time on a given object, and it is prone to select the eye with the least error. Thus, the other eye tends to become amblyopic unless steps are taken to permit the child to learn to use both eyes together. Even in some of these instances, there is a deficiency in development of the fusion reflex.

Refractive errors of high degrees may also lead to amblyopia unless glasses are provided so that the child can see clearly. If the child has no chance of obtaining a relatively clear image, then the eye is apt not to develop visual acuity.

An adequate resume of the incidence of amblyopia ex anopsia in the adult is impractical, but the incidence is higher than one might estimate. In 1945, Downing found among 60,000 selectees for the United States Army, 855 cases of uniocular amblyopia without strabismus, 770 with convergent strabismus, and 295 with divergent strabismus; or a total of 1,920 cases. This means that one out of 35 in this group had uniocular amblyopia, of which the majority could have had normal vision if they had received proper care before the amblyopia became deep-seated after the age of six.

In the latter part of 1954, through the assistance of Mrs. Ruby Hopkins, field representative of the National Society for the Prevention of Blindness, an Oklahoma County Committee was organized with the main purpose being to develop a program for visual screening of the pre-school child. The Delta Gamma alumnae, who have as their national project the program of sight conservation and aid to the blind, actively entered into the program by providing volunteer personnel for doing the testing. This is the ninth city in the United States in which they are now active in such a program, with five more cities soon to be added.

In February 1955, a group of the Delta Gamma alumnae completed a training program for the testing of children. Testing ability was perfected by practicing with their own children and by testing children in a day nursery under the supervision of their instructor. They soon became proficient in working with, and understanding, children of the four to six year age range. It has been well proven that the most efficient test is the use of the Snellen E. Chart, and having the child align either his arms or hands with the position of the three lengths of the E. This group also was instructed in the use of a pen light and observing whether the reflexes are aligned in the center of the pupil. This is known as the Hirschberg Test for finding muscle imbalances. Excitement was profound when the first successful application of this test led to finding five other squints in the same family. Five of these six children were in the pre-school age group.

During the spring following the training period, screening was begun in nursery schools and day-care centers. This procedure had to be abandoned as too inefficient, since it was not furnishing enough children for the volunteer hours consumed.

In the fall of 1955, it was decided to use churches as locations for screening and depending on notices to have parents bring the children in. It may have been that the public was not sufficiently informed, though every effort was made to encourage parents to have their pre-school child tested; but again this approach was too inefficient. During this four month period, 121 children were screened.

In January, aid was sought from the Parents-Teachers Association and school officials in notifying parents that pre-school children could be tested at pre-arranged locations. The results were most gratifying with 524 children being tested in a four month period. During the school year, September 1955 through May 1956, there were 702 children screened with 25 children being referred for visual care.

Under the present plans, churches will be selected for monthly screenings which will consist of two periods a day for three consecutive days. In general, the churches are cooperative in sending notices to mothers of their pre-school children. Also, a notice is placed in the church paper. For each location, the presidents of the P.T.A. of five surrounding schools are contacted to have notices made in school bulletins and announcements made at the P.T.A. meetings. Other public notices are made through radio

and television, newspapers, and by placing posters in surrounding shopping centers. It is anticipated that at least 1000 pre-school children will be screened in the forthcoming year.

The Delta Gamma alumnae have on file and available for use, two films for visual education. "Johnny's New World" is the story of difficulties encountered by a child with defective vision. Too often children will accept poor vision as normal, as they have not known anything else. The second film is for better understanding of the disease, glaucoma, and its serious additions to the number of blind in the United States. Efforts are being made to have various P.T.A. groups show that first film to the parents at their monthly meetings. In this way, it is hoped that the parents will become more acutely aware of visual defects present in children and that these inadequacies can be helped.

Since the institution of the program in Oklahoma City, a second chapter in Tulsa has been organized. The Delta Gamma alumnae volunteers will begin their training program this month and the testing of pre-school children will follow. As time permits, further chapters will be organized to give the state greater coverage.

Occupational Medicine's RELATIONSHIP *and* CHALLENGE TO ALL

EDWARD C. HOLMBLAD, M.D., F.A.C.S.

THE AUTHOR

Dr. Edward C. Holmblad is a graduate of Rush Medical College. He is managing director of the American Industrial Medical Association. He is also a Fellow of the American College of Surgeons.

The term "Occupational Medicine" is a recent adaptation including industrial medicine and surgery as well as environmental medicine. A recent definition agreed upon at the Conference on the Education of Physicians for Industry in Pittsburg, December, 1955 is—"Occupational medicine is that branch of medicine which deals with the relationship of man to his occupation, for the purpose of the prevention of disease and injury and the promotion of optimal health, productivity and social adjustment."

This field of medicine dates back to Ramazzini and even before that time. In our country it has had a gradual development from the late 1800s to the early 1900s. The treatment of injuries in railroad work and the physical examinations of engineers and train operating employees are examples of earlier industrial medicine. There are at present over 4,000 railroad surgeons in one association and many more who do some medical work for railroads. The advent of the Workmen's Compensation laws accelerated the development of Industrial Medicine from 1910 to the present date. This industrial medical work has become so universal that practically every physician comes in contact with this type of case quite frequently in his practice.

There is a relationship between industrial medicine and all the specialties that I like to compare to the relationship of pediatrics to all the other specialties. The pediatrician consults with the cardiologist, the surgeon, the radiologist, the urologist, the neurologist, etc. in the care of his patient from infancy to the early teen years. The industrial physician is concerned with the optimum health of the worker in industry from the time he starts to work until he turns him over to the specialist in geriatrics. It is necessary for him to consult with internists, surgeons, radiologists, urologists, neurologists, etc. to obtain the best diagnosis and medical care. It is important that these consulting specialists understand the relationship of the specific medical problem to the actual work done by the employee. Sometimes abdominal cramps and pain in the painters are diagnosed as "lead colic" and "lead poisoning." It is important to know whether the paint that is used actually contains lead. If there is no lead in the paint

used, it is impossible for the employee to have lead poisoning from that paint. It is most difficult to differentiate between the causative and the casual relationships of work environment.

A toxic product with which an employee works may cause certain symptoms and pathology. On the other hand, the fact that he works with this product may be only coincidental.

It is important that all physicians have this understanding of the industrial relationship and point of view in examining, diagnosing and treating the industrial patient.

One of the best illustrations of the growing importance of occupational medicine appears in the April 21, 1956 issue of the *Journal* of the American Medical Association in the form of an editorial on page 1411 entitled "Industry Needs Physicians." It is well worth your while to read this one column editorial. Thirty years ago such recognition would have been impossible. The formation of the Council on Industrial Health of the American Medical Association and the appointment of State and County Medical Society committees on industrial health further attests to its importance as a growing field in the practice of medicine.

Because of the widespread diversification of employment, every physician is vitally interested in occupational medicine. Take the small rural community for instance with many farmers and agricultural workers. Years ago there were few industrial accident hazards and practically no occupational diseases. Since the farm has become mechanized, there are great hazards of serious industrial injuries. Every physician must become aware of the importance of safety programs, safety information and safety consciousness to the farm worker. Just one mangled arm caught in a corn picker or shredder will convince the treating physician of the value of safety programs. Likewise with occupational diseases the use of insecticides has brought about occupational dermatitis and occupational poisonings, even death, that shows how important it is that every physician, including all general practitioners, have knowledge of the toxicity of insecticides.

The field of occupational medicine offers a remarkable challenge to the medical profession. Just think how important it is to keep people well and in optimum health. The pre-placement and periodic health examinations of workers are most helpful in revealing unknown pathology. At least 10 per cent of the patients with a hernia are not aware of its existence until some pre-placement or insurance examination reveals its presence. Sugar in the urine, abnormal blood pressures, changes in vivion and abnormalities found in routine chest x-ray surveys are but a few of the findings revealed in occupational health examinations.

I know of no field in medicine where it is absolutely necessary to make a correct diagnosis. You have to be so sure of your findings and diagnosis that it may be necessary to back it up by testimony in court. And while we are on this subject, may I plead with all of you not to shirk your responsibility to get honest and medically reasonable testimony before the courts of law as well as industrial commission hearings. If our best qualified physicians refuse to go into court to see that medical justice is done, then the field is wide open for the professional medical testifier and charlatan. Do not be afraid to appear in court because the judge or commissioner will see that you are not abused and that you will be allowed to state your honest medical opinion.

Let's look at some of the other phases of occupational medicine's challenge. The rehabilitation of the injured or sick worker should start at the onset of illness or the time of the accidental injury. It is important to assure an injured worker that he will be able to resume work, even his regular work when he recovers. I believe every patient is entitled to some evidence of improvement from day to day. Changes in diet from liquid to soft to regular nourishment are such evidences. Also how thrilling it is when making hospital rounds to tell a patient he can sit on the edge of the bed or sit up in a chair or have bathroom privileges. There is no reason why you should not indicate these steps of improvement and recovery. It is also wise to plant the thought that soon he will be able to return to work. I usually tell a patient a week or two before I expect to release him for work to go down to his plant or place of employment and talk to his boss about suitable work that he can do in the

next few weeks. Then when he is told to go back to work he is prepared for it. I do not like to use the phrase "light work" when releasing a patient because the boss and fellow workers think he is using his injury for special privileges. I much prefer the term "modified work for two or three weeks" as a less offending method of releasing an employee to go back to work.

Then also I think it is important to discuss the question of permanent disability with those patients where permanent disability is anticipated and some sort of settlement is in order. I usually tell such patients that I know there may be some permanent disability or disfigurement but I also know there will be continued improvement in the next six months to a year. I tell them I will call them back for a disability evaluation examination at some future date so that their claim will not be outlawed. Many workers or their attorneys are anxious to force settlement consideration while swelling, limitation of motion, muscle atrophy and red scarring exists. If it is reasonable to anticipate improvement in these conditions, it is too early to estimate the permanent disability. It is not proper to estimate the permanent disability for settlement at the same time that it is reasonable to expect the employee to return to work. It is good practice to see the patient occasionally, say at weekly or two-week intervals, to see how he is working back into his job and suggest increased activity if that is in order.

The industrial commissions require medical reports both in cases of accidental injury and occupational disease. To delay filling out such reports or to give inadequate reports may jeopardize the payment of compensation to which the worker is entitled.

In cases of non-occupational illness or injuries, it is important to have accurate medical certificates. I feel that where an employer contributes any or all of the premium for sickness benefits then it is proper to evaluate that illness or disability as often as is reasonable or proper. Hospitalized patients usually get competent medical reports and medical certificates. It is unfortunate that so many medical certificates of disability are inadequate or unreliable. Every physician has had some patient ask him to make out a medical certificate for three or four weeks of disability so he can collect sickness benefits. To fill out such a certificate without having the patient under your care for that period is dishonest and fraudulent. It is difficult to get accurate and reliable diagnoses. The best method of counteract this is to refuse to pay benefits for such diagnosis as nervous fatigue, general debility, anemia, run-down condition, needs six weeks' rest, etc. It has been almost amusing to notice the attitude of some employees when you tell them they can have six weeks off but without sickness benefit. In most cases they say they will come back to work if they do not get sickness benefit.

I have had some strange and disheartening experiences in approving Blue Cross, Blue Shield, Major Medical and other medical and surgical indemnity benefits in the Chicago area. Some of our physicians seem to think they are entitled to their regular fee in addition to the Blue Shield or indemnity payments. If they continue to exploit these professional fee payments, they will force some type of complete medical care or socialized medicine on all of us.

The practice of occupational medicine can be a very challenging and rewarding experience. It can be done as a single case or as an on call physician in a plant. Since we have so many small industries, much of this work will have to be done by the general practitioners, the internists, surgeons, and as supplementary work for the young specialists. To get the most out of this work and to render the best possible service, it is important that the physician spend some time in the plant or to at least make periodic visits to the plant so that he sees and understands the environment and working conditions.

Many medical directors in industry have started out as part time industrial physicians and have gradually become full time specialists in the field of occupational medicine. It is gratifying to know that such positions demand the best possible clinical and professional ability. They continue to be physicians primarily and as such get the enjoyment and job satisfaction of their chosen profession.

Special Article

The Role of the A.M.A. *in* MALPRACTICE PREVENTION

WILLIAM J. McAULIFFE, Jr.

THE AUTHOR

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A Summary of the Malpractice Situation Over the Nation

One of the more alarming developments in professional liability is that the size of verdicts rendered in such cases is on the increase. Let me tell you the facts of a recent California case which resulted in the highest verdict that we know of.

The plaintiff in this case, a 54-year old man, employed as a stock clerk, had suffered intermittent claudication in the calves of both legs for about a year. He had been attended by a specialist in internal medicine who treated him conservatively with drugs intended to improve circulation. When the patient did not respond, he was referred by the internist to the defendant doctor, a specialist in vascular surgery. The surgeon examined the patient and found complete absence of pulsations from the femorals down. The plaintiff had all the other symptoms of an obstruction in his aorta and the defendant surgeon recommended that he enter the defendant hospital for further studies to determine if an operation could be performed to improve his condition. The plaintiff claimed he understood he was entering the hospital merely for some routine x-rays.

Now up to this point the patient had no sensory or motor nerve disturbances.

X-rays were taken of the plaintiff's chest and abdomen. Then two days later, a translumbar aortogram was taken.

I shall relate the highlights of this procedure. The plaintiff was taken to the x-ray department. The defendant doctor was present only at the start of the procedure. He did not participate in it. The plaintiff was given an anesthetic by an anesthetist. A resident in surgery inserted a 16-gauge needle into the aorta in the normal way without any difficulty. Thirty cc. of sodium urikon were injected through the needle and a series of films were taken. Upon examination of these films, with the patient still under anesthesia, the resident in surgery, after consultation with the radiologist, decided that an additional run should be made in an attempt to visualize collateral circulation lower down in the body. An additional injection of 20 cc. of sodium urikon was made without changing the position of the needle. Then the patient was returned to the room, apparently in good condition. The next morning at about 5:00 a.m. it was found that the patient was completely paralyzed from the umbilicus down. He had a transverse myelitis which unquestionably was permanent. Complete paralysis of the lower extremities, bowels and bladder was present. He was a permanent paraplegic.

The plaintiff claimed that the defendant surgeon did not himself perform the procedure as he had expected and that he was not advised in advance of the procedure that there were any risks or dangers attendant to it. He further claimed that 50 cc. of sodium urikon was too much and exceeded the recommended dosage of the manufacturer. The manufacturer's brochure indicated that 15 cc. of sodium urikon was the safe limit. However, there was testimony in behalf of the defendant that other patients had tolerated without any harmful effect more than 15 cc. of this fluid. The plaintiff also

complained of two runs being taken.

What caused the paralysis was difficult to establish. The defendant doctor and another expert believed that there had been an occlusion of the blood supply to the spinal cord which resulted in cecrosis of the cord. A neurosurgeon believed that the complication was due to a toxic reaction to the drug.

The case was submitted to the jury on the theory of resipsa loquitur, which does not require proof of negilgence by the plaintiff as there is a presumption or inference of negligence under this doctrine which stems from the untoward result. Thus, under this legal doctrine, the effect is that it is virtually necessary for the defendant to explain a way to the untoward result, which as I have already indicated, was very difficult if not impossible. The jury reached a verdict in favor of the plaintiff against both defendants, namely the defendant vascular surgeon and hospital in the amount of $250,000, which was reduced to $215,000 by the trial court. This case is now on appeal by both defendants.

Another recent case of a high verdict involved an 18-year old wife of a navy man who was allegedly given an improper spinal anesthetic when admitted to a navy hospital for childbirth. The consequence was arachnoiditis and paralysis from the chest down. Suit was brought under the Federal Tort Claims Act and a Federal judge, sitting without a jury, awarded $190,000 to the wife and $20,000 special damages, making a total of $210,000. This is believed to be the largest single personal injury award yet made under the Federal Tort Claims Act, or by any Federal judge sitting without a jury.

Both of these cases were decided in 1955.

Next, switching from specific cases, I shall give you a picture of professional liability in the United States as we find it.

The American Medical Association has been conducting a study of professional liability insurance and claims prevention programs. In this connection the Law Department sent questionnaires to the District of Columbia and all of the State Medical Societies, designed to elicit extensive information on this subject.

We have summarized the information received in response to these questionnaires, and I would like to outline for you some of the facts that have been obtained. (1) The following are the causes and aggravating circumstances of personal liability claims most frequently listed thus far: (a) imperfect results after orthopedic surgery, (b) x-ray burns, (c) foreign body left in a patient after surgery, (d) failure to obtain consent prior to surgery, (e) inaccurate prescriptions of drugs or improper diagnosis, (f) criticism of one doctor by another, (g) excessive fees, and (h) poor physician-patient relationship. One state said that at least 90 per cent of the claims in their state had some justification. Another said that only 30 per cent had merit. (2) The effect of a professional liability suit on the reputation and practice of a physician is slight, if any. A few states indicated that the effect is greater in small towns. (3) About 45 companies, both foreign and domestic, provide some type of professional liability insurance coverage. (4) Professional liability insurance is available and not difficult to obtain. (5) The limits of professional liability insurance carried by physicians vary considerably. (6) Twenty-two states have claims-prevention or review programs on a state level and two states have such programs on a county level. Only twelve states indicated that they offer educational courses with their claims-prevention programs. (7) Twenty-two states have a claims-review program with a committee or staff supervising the program.

That briefly gives you a quick review of professional liability throughout the country as disclosed by the societies in response to our questionnaire.

A very interesting analysis has been made by Doctor J. F. Sadusk of the professional liability picture in the Alameda-Contra Costa Medical Association in California. I would like to give you some of the facts as disclosed in Doctor Sadusk's analysis. Incidentally, a report of this appears in the Alameda-Contra Costa Medical Association Bulletin of May, 1955, in an article entitled "An Analysis of the Professional Liability Program in Alameda-Contra Costa County—1946 through 1954."

Doctor Sadusk found that: (1) 67.6 per cent of the physician membership was between 35 years old and 54 years old and that this group accounted for 78.4 per cent of the professional liability incidents of the

society; (2) ninety-two physicians had one incident each, ten had two incidents each, three had three, and one had four: the fourteen physicians who had more than one incident each constituted only one per cent of the County Medical Association membership, but accounted for 27 per cent of the ad damnum (amount of money asked for in suit for damages) filed; (3) 68 per cent of the claims were surgical in nature, 18.4 per cent were medical and the rest involved radiological, equipment and other problems; (4) in the surgical incidences, obstetrics and gynecology, orthopedics and general surgery accounted for 53.9 per cent of the total of such incidents; (5) 70 per cent of the professional liability incidents occurred in a hospital; and (6) the number of malpractice incidents per 100,000 admissions ranged from zero in the case of one hospital to 56.4 incidents per 100,000 admissions in another hospital, with the medium being 12 per 100,000 admissions.

Another California doctor, Andrew Sandor, M.D. of Alhambra, has tabulated all of the reported cases in the United States. A reported case is a case which appears in the law reports and thus has reached at least an appellate court: the cases which are not appealed from the trial court are not reported in the law reports. I believe that Doctor Sandor's tabulation makes for a very interesting analysis of the professional liability situation throughout the country.

The first reported case in the United States is *Cross v. Guthrie* which was decided in 1794 in Connecticut. The first reported case in Oklahoma is *Champion v. Keith*, which was decided in 1906. Of possible historical interest is that Abraham Lincoln represented the physician in the first reported case in Illinois, *Ritchey v. West*, which was decided in 1860. I regret to say that Mr. Lincoln and Doctor West lost. This tabulation of Doctor Sandor includes reported cases up to 1950. On the basis of the total number of reported cases up until 1950, California ranks first with 144, New York second with 116 and Oklahoma 19 with 31.

Summary of the Role of the A.M.A. in Professional Liability Education Programs

The American Medical Association through its Law Department, is very much interested in professional liability education programs. This study of professional liability insurance programs and claims-prevention programs which I have already referred to, is perhaps one of the most important projects undertaken by this Department since its creation in August, 1954. It was initiated as a result of a number of resolutions presented to the House of Delegates by State Medical Societies requesting advice and assistance in this field. Before the study is completed, we intend to make a survey of the professional liability experiences in other countries, a survey of practicing physicians, a survey of attorneys who participate in professional liability claims, a survey of insurance companies who offer professional liability insurance, a survey of judges who sit in judgment of physicians in professional liability cases, an analysis of state legislation and reported cases and a survey of comparable fields of negligence actions. Also, we propose to prepare and publish special articles on professional liability in the Journal of the American Medical Association on such subjects as the following: The Law of Professional Liability; the Res Ipsa Loquitur case; the Rule of Respondeat Superior; the History of Professional Liability Claims in the United States; the History of Professional Liability Claims in Other Countries; Professional Liability Claims Prevention; Put It in Writing Doctor; Hazardous Therapy; and Timely Use of Consultants.

In addition to this study this year we conducted three medicolegal symposiums, one in Chicago, one in Omaha and one in New York City in which we attempted to promote better understanding between the legal and medical professions. One of the subjects discussed at all of these meetings was professional liability. Next month we are having a meeting of all the attorneys of organized medicine, both state and national, at which professional liability will be discussed. In addition, another activity which we have undertaken in an effort to foster professional liability education programs has been to provide a member of the Law Department for meetings of county and state medical societies to discuss this topic just as I am discussing it this evening.

(Continued on Page 352)

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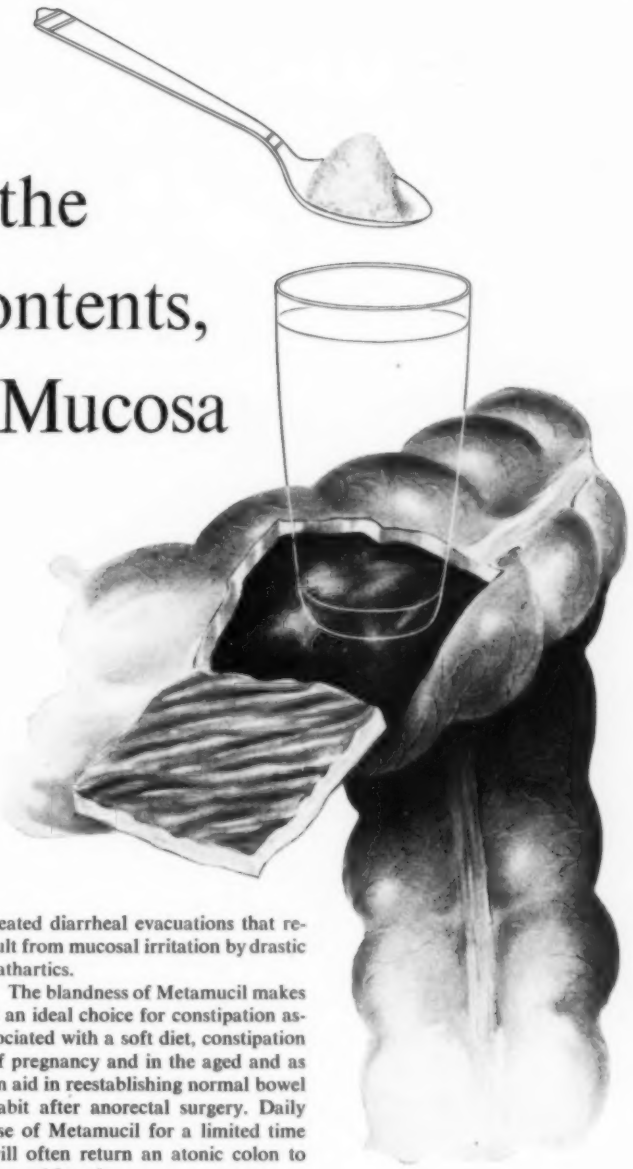

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The blandness of Metamucil makes it an ideal choice for constipation associated with a soft diet, constipation of pregnancy and in the aged and as an aid in reestablishing normal bowel habit after anorectal surgery. Daily use of Metamucil for a limited time will often return an atonic colon to normal function.

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SEARLE

Association Activities

PRESIDENT'S LETTER

Once more our government is asking—subtly demanding—the Medical Profession to assume another important and arduous task.

Public Law 569 could be construed, as saying to the dependents of members of the Uniformed Services, that they are not capable of providing themselves with good medical care. Another possible deduction is that the government is telling the Medical Profession to carry out the mandates of this law or there will be federal intervention.

Is all this part of a trend? Will housing, food, clothing, etc., be next on the agenda? What other branches of the government, what other organizations, will ask for the same emoluments? We must be extremely careful not to be nailed to the same cross we now support.

Be that as it may, the members of the O.S.M.A. must: First set up the machinery necessary to provide the Medical care to those so designated. This will entail creating and adopting a Fee schedule, which must meet the approval of some red tape and eight copy Federal Agency. Second we must bring into being or designate an organization to administer the mechanics involved, i.e., determining whether this or that procedure was indicated,—adjudicating fees, collecting from Uncle Sam, paying the Doctors, and any other duties usually assigned an umpire. To be alive is fortunate, of course, when you are confronted with more triplicate forms, life may not be so gay.

But what are we going to do? We must approach the problem open-mindedly and in a spirit of inquiry, find the bases for postulates, and eventually the obvious solution will occur. In this, another immense confusion, we will accomplish our task in a workmanship like manner.

While you are esconsed in your favorite chair or pursuing your favorite pastime, the executive staff and several members of this association will be laboriously hacking away at this allocated problem. If you should think of frugality, all of this is worth more to each of YOU than one year's dues plus any assessment.

Tom McClure M.D.

President

"I'll take care of that later . . ."

He was a wonderful husband and father, a great doctor, a man who was extremely meticulous in everything he did—except in his planning for his family's future in the event of his death. In this respect he became the victim of procrastination—"I'll take care of that later."

What he could have accomplished so easily now becomes the biggest problem his wife will ever have to face—there is no semblance of order in the estate he left, in fact his widow has no assurance at this moment that she will even be able to provide an education for the children. The expenses of settlement of the doctor's estate will run as high as one-third of all he left! Indeed, the price of neglect in this case will run much higher than the doctor ever realized because—"I'll take care of that later."

Have you provided for the protection and security of your family, Doctor? If you have neglected the vitally important business of arranging for the transfer of your estate in the event of your death, don't delay another day! Our Trust Department will be happy to discuss this urgent matter with you immediately. Now—today—call REgent 6-1531 and ask for our Mr. Scott. He will be happy to call on you at your convenience.

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THE FIRST
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A.M.A. in Malpractice Prevention

(Continued From Page 348)

The AMA can, and does perform the services which I have just outlined, but it is not constituted to intercede or participate in civil actions between a physician and his patient. Furthermore, the AMA is not staffed to perform such a service. Another reason for the AMA's inability to assist in professional liability suit is that if the AMA did perform such a service, it would lose its present tax status. The AMA for the purposes of taxation in considered to be a business league. If it assisted doctors in professional liability suits, benefits of the Association would be then enuring to the individual members of the Society. Thus the AMA would be in a business and would be taxed as any other corporation or organization that is in business. Furthermore, if the AMA did provide this service, it would mean that one doctor would be paying for the expenses of another incurred in litigation.

Summary

The size of verdicts in increasing. There can be no question about it. The AMA is doing and will continue to do everything it can in professional liability education. The AMA is currently engaged in a survey that it hopes to conduct in an objective, judicious manner, with the view of formulating a comprehensive report on the subject of professional liability as it exists in the U.S., plus affirmative suggestions for reducing such claims. But it can not participate in the individual lawsuits of physicians.

Oklahomans Meet At Flight Nurse Graduation

The graduation of Flight Nurse Class 56-C at the Gunter Branch—School of Aviation Medicine recently brought together coincidentally a group of people who received at least a part of their professional training in Oklahoma.

Colonel Fratis L. Duff, Commander of the Gunter Branch—School of Aviation Medicine since October, 1953 was graduated from the University of Oklahoma School of Medicine. To the right of Colonel Duff is Mrs. Duff, a graduate of Wesley Hospital School of Nursing. Standing next to Mrs. Duff is Mrs. Richard W. Simpson, graduate of St. Anthony School of Nursing. Mrs. W. W. Brier on Colonel Duff's left, is a graduate of Oklahoma City General Hospital and Captain Cora Conerly, Flight Nurse at Patterson Air Force Base, received her professional education at the University of Oklahoma School of Nursing.

Mrs. Brier has the distinct honor of being the first Flight Nurse. She participated in the graduation ceremonies at Gunter by pinning the wings on the graduates.

Golden Anniversary, Southern Medical Association

Physicians who are members of their county and state medical societies are cordially invited to attend the Golden Anniversary Celebration of the Southern Medical Association, October 2-3, to be held at the Read House, Chattanooga, Tennessee.

The Golden Anniversary Celebration will begin with a dinner meeting at the Read House, Chattanooga, on Tuesday evening, October 2. A feature of that program will be an address by R. L. Sanders. M.D., Memphis, immediate past-President of the Southern Medical Association, on "Fifty Years of Medicine in the South." Doctor Sanders graduated in medicine at Nashville in 1906, his fifty years of practice running concurrently with the fifty years of the Southern Medical Association. Dwight H. Murray, M.D., Napa, California, President of the American Medical Association, will represent the AMA at the Celebration.

A feature of the Wednesday morning session will be the unveiling of a plaque to be placed in the Read House commemorating the birth of the Southern Medical Association there fifty years before on that date.

A group of physicians from Alabama, Florida, Georgia, Louisiana, Mississippi and Tennessee met at the Read House in Chattanooga on October 2-3, 1906, and organized the Southern Medical Association. The founding fathers in the Constitution and By-Laws they adopted at Chattanooga stated "the exclusive purpose of this Association shall be to develop and foster scientific medicine . . . It shall not at any time take active part in any economic, political or sectarian questions or concerted movements for securing legislative inactments." It was to be devoted exclusively to scientific medicine. That same Constitution and By-Laws made it necessary for a physician to be a member of his county and state medical societies and to be eligible to membership in the Southern Medical Association. All of the above has never been changed. Several years later the physicians who were members of the state and county medical societies in Arkansas, District of Columbia, Kentucky, Maryland, Missouri, North Carolina, Oklahoma, South Carolina, Texas, Virginia and West Virginia were made eligible to membership.

Patterson Brothers Receive 50-Year Pins

James L. Patterson. M.D. and Fred L. Patterson, M.D. of Duncan were honored recently by the Stephens County Medical Society, when W. S. Ivy, M.D., oldest member of the organization, presented them with 50-year pins.

The two brothers were reared in St. Joseph, Missouri, and attended the Ensworth Central Medical College there. Both of them graduated on the same night, fifty years ago.

There is 22 months difference in their ages, and when they graduated, Doctor Fred was only 20 years old and too young to practice, so he waited until 1908 to settle in Fargo, Oklahoma.

Doctor Jim's first practice was in Mutual, Oklahoma, 20 miles away. It was an all-day trip to visit each other.

In June, 1917, they both enlisted in the Army as captains in the Medical Corps. When they were discharged in 1919, they moved to Woodward and set up practice together. In 1922, three other doctors joined them to form the first clinic in the state of Oklahoma.

In 1925 the clinic was dissolved, and Doctor Jim moved to Elk City for a year, then to Duncan the next year. Doctor Fred remained in Woodward until 1934, when he moved to Carnegie and built a hospital there. He remained in Carnegie until coming to Duncan in 1945.

Standing, left to right: James L. Patterson, W. S. Ivy and Fred L. Patterson.

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Clinical Society To Hold 26th Annual Meeting

Members of the Oklahoma State Medical Association are cordially invited to attend the 26th Annual Conference of the Oklahoma Clinical Society, October 22-25, 1956 to be held at the Biltmore Hotel, Oklahoma City, Okla.

Distinguished guest speakers of the Fall Clinical Conference will include: Albert Behrend, M.D., Philadelphia, Pa.; William H. Beierwaltes, M.D., Ann Arbor, Mich.; Donald J. Birmingham, M.D., Cinicinnati, O.; Ethan Allan Brown, M.D. and John F. Brigler Jr., M.D., Boston, Mass.; Willis E. Brown, M.D., Little Rock, Ark.; Vincent P. Collins, M.D., Houston, Tex.; Kendall B. Corbin, M.D., Rochester, Minn.; A. Keller Doss, M.D., Fort Worth, Tex.; Edward T. Evans, M.D., Minneapolis, Minn.; Patrick J. Fitzgerald, M.D., Brooklyn, N.Y.; Rufus C. Goodwin, M.D., San Francisco, Calif.; Gordon McNeer, M.D., New York City, N.Y.; Gordon Meikeljohn, M.D., Denver, Colo.; Joseph H. Ogura, M.D., St. Louis, Mo.; Henry B. Turner, M.D., Memphis, Tenn., and Harold W. Elley, Ph.D., Wilmington, Del.

An outstanding program of postgraduate teaching will be delivered by the guest speakers who have been selected from various medical and teaching centers throughout the nation. In addition, a new feature will be specialty lectures, and there will also be daily luncheon round table question and answer sessions, and a clinical pathologic conference.

The entertainment will include dinner meetings, the annual Clinic Dinner dance and Specialty Group dinners.

For further information, address: Executive Secretary, Oklahoma County Medical Society, 503 Medical Arts Building, Oklahoma City, Oklahoma.

HAVE YOU HEARD?

FORREST BROWN, M.D., former director of the Seminole county health department, was appointed assistant director of local health services for the state department of health at Oklahoma City.

A native of Oklahoma, he attended Cameron college at Lawton and the University of Oklahoma School of Medicine.

W. D. STOVALL, M.D. has been appointed county doctor for the city of Sand Springs.

A. B. CARNEY, M.D. and JOHN E. MCDONALD, M.D. have been named to the Credentials Committee of the United States Division of the International College of Surgeons.

THE UNIVERSITY OF OKLAHOMA MEDICAL CENTER has been presented with a Van de Graaff X-ray generator by the Donner Foundation of Philadelphia. The 2-million volt X-ray therapy unit will be delivered next year after special facilities have been built to house it.

JOHN A. SCHILLING, M.D. has been appointed the first fulltime Head of the Department of Surgery at the University of Oklahoma School of Medicine. He was Assistant Professor of Surgery at the University of Rochester School of Medicine and Dentistry before coming to Oklahoma.

LOUIS J. WEST, M.D. has now assumed his duties as fulltime Head of the Department of Psychiatry following his release from active duty with the airforce.

O. H. PATTERSON, M.D. has recently opened offices in the Joseph Building, Sapulpa, Okla.

ROBERT V. BOLENE, M.D., formerly of Enid, has opened a medical practice in the Community building at Ponca City, Okla.

I. F. STEPHENSON, M.D. has assumed duties as President-elect of the Alva Rotary Club.

ARVIN C. ROBERSON, M.D., formerly from St. Anthony hospital, Oklahoma City during his residency, has joined the staff at the Anadarko Hospital and Clinic, Anadarko, Okla.

ROGER G. JOHNSON, M.D. has opened his offices in the Medical-Surgical Clinic, Frederick, Okla.

Seventy-Six Attend Clinical Symposium

The McAlester Clinic and the McAlester Clinic Foundation under the joint sponsorship of the Department of Postgraduate Education, University of Oklahoma School of Medicine, presented their Second Annual Symposium, August 4-5, at the Aldridge Hotel in McAlester. Seventy-six Oklahoma physicians attended the lectures.

Outstanding speakers on the program included:

Malcom E. Phelps, M.D., El Reno; Fred D. Switzer, M.D., C. K. Holland, M.D., Thurman Shuller, M.D., H. C. Wheeler, M.D., S. L. Norman, M.D., L. S. Willour, M.D., George M. Brown, Jr., M.D., E. H. Shuller, M.D., Bruce H. Brown, M.D., McAlester; John J. Donnell, M.D., Allen E. Greer, M.D., Joe M. Parker, M.D., Peter E. Russo, M.D., Oklahoma City; M. P. Capehart, M.D. and Worth M. Gross, M.D., Tulsa.

Topics which were discussed on Saturday afternoon included presentations on pediatric aspects of trauma, chest injuries, eye injuries, head injuries, burns, diabetes in trauma, and fractures of the elbow in children. The closing session was a panel discussion on coronary heart disease.

A Dinner-Dance, attended by physicians, wives and guests, was held Saturday evening at the McAlester Country Club at which time Malcom E. Phelps, M.D., El Reno was guest speaker on the dinner program. Doctor Phelps, President-Elect of the American Academy of General Practice, pointed out the various responsibilities that a physician has to his patient, his community and his family.

Pictured left is L. S. Willour, M.D., McAlester presenting the 50-year pin to George R. Booth, Sr., M.D., Wilburton.

Highlight of the evening, was the presentation of a 50-year pin to George R. Booth, Sr., M.D., of Wilburton. The presentation was made by L. S. Willour, M.D., McAlester who paid homage to Doctor Booth and the half century of service which he has rendered to humanity.

Recreational activities for Sunday morning included fishing and a golf tournament. The golf tournament was held at the McAlester Country Club and was sponsored by the Pfizer laboratories. Alan S. Cameron, M.D., Muskogee, who tied for first place at the recent State Medical Association golf tournament, was the winner of this event.

Following the recreational activities, a session on Clinical Techinques was held at the McAlester Clinic. Topics discussed were: "Kirschner Wire Technique for Hip Pinning"; "Erythroblastosis and Exchange Transfusion"; "Gastroscopy and Its Application"; and "Routine Operative Cholangiography."

A Cinema Clinic was held and films were shown entitled, "Heart Disease", "Diagnosis of Acute Abdominal Problems", and "Bronchoscopy and Chest Anatomy Management".

The afternoon session was devoted to papers on Malignancy. Topics discussed were "Skin Lesions"; "Carcinoma of Lung"; "Malignant Change in Osteochondromas"; "Control of Pain—Neurosurgical Aspects"; "Malignancy of the Colon"; "Present Concept of X-ray and Radium Therapy." The closing session was devoted to a panel discussion on "Massive Upper Gastrointestinal Tract Hemorrhage."

Eight hours of Category I credit was allowed by the American Academy of General Practice.

ANNOUNCEMENTS

Mississippi Valley Medical Society
21st Annual Convention, September 26, 27, 28, 1956, Hotel Morrison, Chicago, Illinois.

American Medical Writers Association
13th Annual meeting, September 28-29, Hotel Morrison, Chicago, Illinois.

Oklahoma Clinical Society
October 22, 23, 24, 25, 1956, Oklahoma City, Okla.

Southern Medical Association
Golden Anniversary Meeting, November 12, 13, 14, 15, 1956, Washington, D. C.

American Medical Association Clinical Meeting
November 27-30, 1956, Seattle, Washington.

Oklahoma Academy of General Practice
February 4, 5, 1957, Biltmore Hotel, Oklahoma City, Okla.

Oklahoma State Medical Association
Annual Meeting, May 5, 6, 7, 8, 1957, Tulsa, Okla.

International College of Surgeons
10th Biennial Congress combined with the 21st annual Congress of the United States and Canadian Sections. September 9, 10, 11, 12, 13, 1957, Chicago, Illinois.

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Book Reviews

THERAPY OF FUNGUS DISEASES: An International Symposium. Edited by Thomas H. Sternberg, M.D., Professor of Medicine (Dermatology) and Assistant Dean for Postgraduate Medical Education and Victor D. Newcomer, M.D., Associate Professor of Medicine (Dermatology), School of Medicine and Medical Extension, University Extension, University of California at Los Angeles. First Edition. Cloth. $7.50. Pp. 332. Little, Brown and Company. Boston-Toronto.

In the last decade, there has been more and more interest in the field of fungus diseases, stimulated particularly by the experiences and problems encountered in the Pacific areas during World War II. This book is a report, carefully edited, of an International Symposium on therapy of fungus diseases held June 23, 24 and 25, 1955, at the school of Medicine and Medical Extension, University of California at Los Angeles. A total of 208 scientists participated, representing 24 states and eight foreign countries. The material presented at the symposium has been well organized and presented by the editors, so that as a result each paper is easy to read and follow. There are few illustrations but none are expected, however, the tables and charts are excellent and well-presented so that the results of laboratory procedures are clear, as well as the results of the various therapeutic agents reported.

There is much information presented on the antifungal antibiotic mystatin revealing its use in various laboratory procedures, in culture media, animals and results obtained to date in clinical patients. Quite informative is not only the use of Mystatin in Superficial fungus diseases, but in the deep fungi. Other antifungal agents reported on include the aromatic diamidines, nitrostyrenes, filipin, actidione, undecylenic acid, chlorquinaldol and others. Not only are many thereapeutic aspects of the various antifungal agents discussed, but to those interested in mycology, the discussion of the biologic aspects of fungus infections is quite important and interesting.

Another interesting and stimulating feature is the information presented by the mycologists on the study of the superficial and deep fungi in their respective countries, namely, India, France, Argentina, Brazil, Mexico, the Philippines and the Ukraine.

This excellent edition will appeal particularly to those interested in dermatology and mycology, but many of the papers will be of value to those dealing with the more common fungi daily, as an aid to their control and eradication. Paul O. Shackelford, M.D.

CIBA FOUNDATION SYMPOSIUM ON HYPERTENSION HUMORAL AND NEUROGENIC FACTORS. Edited by: G. E. W. Wolstenholme and Margaret P. Cameron. Little, Brown & Company, Boston. 1954. 285 pages, 73 illustrations. $6.75.

This volume contains the complete papers and discussions of Humoral and Neurogenic Factors in Hypertension from the Symposium held in London, July 27-30, 1953.

Twenty-one papers were presented, some of which were of a general review type such as Irvine Page's on Neural and Humoral Control of Blood Vessels and Heyman's discussion of some new aspects of Reflex Blood Pressure Regulation and Hypertension. Other papers discuss the Kidney in Experimental Hypertension, Water and Electrolytes in Experimental Hypertension, and Chemical Screening Methods for the Diagnosis of Phaechromocytoma.

Some controversial ideas were presented —i.e., Jimenez Diaz' suggestion that noradrenaline is released from the arterial wall following stimulation of the arterial nerve supply, and Helmer's presentation of a sustained pressor material possibly related to renin.

The informal, often lively discussion after each paper adds considerably to their value and emphasizes the fragmentary stage of our present day knowledge.

This volume is recommended for the internist, particularly if he is interested in diseases of the circulation.